CHILD HEALTH IN NEW YORK CITY*

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TRADITIONALLY, the health of children in New York City has been shaped by the city's complex and changing socioeconomic patterns. Increasingly, health problems of children in New York City reflect the poverty in which many children and their families live. Because these conditions include problems and forces against which medicine and the health care system historically have not been very effective, our major challenge during the coming years will be to make the delivery of health services more accessible to the children who most need them.

There are just under 2 million children and youth aged 19 years and under in New York City, comprising 28% of the city's total population. Adolescents between 15 and 19 years of age comprise the largest cohort of children in the city; the relatively low birth rates of the 1970s resulted in smaller numbers of children from 5 to 9 and from 10 to 14 years of age, though an increase in the birth rate in the early 1980s has resulted in a "baby boom echo" of preschoolers four years old and under. Our children are almost evenly distributed among whites, blacks, and Hispanics.

By 1980 families headed by women constituted more than one quarter of all families in the city, with a median income less than $6,000, roughly one third of the median income of all city families.

Nearly 40% of all children in New York City live in poverty. Approximately 80% of Hispanic and black children under 18 years of age are poor or near poor, compared with 38% of white children under 18 years. Twenty-three percent of city children aged 19 years and younger have no health insurance, while one third receive Medicaid. Children four years of age and under were more likely to be uninsured than children of any other age group.

The infant mortality rate in New York City in 1986 was 12.8 infant deaths per 1,000 live births, down from 13.4 in 1985. (Preliminary figures for 1987

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indicate a slight upward trend to 12.9.) The overall citywide rate masks wide differences among various health districts. While the infant mortality rate for 1986 in Maspeth/Forest Hills in Queens was 6.2 per 1,000 live births, the rate in Central Harlem was more than four times higher, at 27.6. Overall, black infants have a mortality rate twice that of white infants.

Of growing concern is the increase in live births complicated by maternal substance abuse, especially cocaine. Maternal substance abuse was reported in almost 2% of all live births in the city in 1986. Among infants registered in the Health Department's Infant Health Assessment Program, which tracks infants at risk for developmental disabilities, 48% had maternal substance abuse. In some of the municipal hospitals this factor can account for up to 70% of infants at risk.

Against this background, I propose three ways to make delivery of health services more accessible to children: through redirecting funding streams, harmonizing the activities of the Health Department and the Health and Hospitals Corporation, and reaching children in need more effectively by strengthening outreach and advocacy. I shall discuss each of these in turn.

First, more funding needs to be channeled toward prevention and early intervention activities. Presently, inpatient acute care is among the largest items in the city's child health activities through city agencies. The 14% of the Medicaid enrolled children in the zero-to-four-year-old age group who had inpatient stays in 1987 used 41% of all Medicaid funds expended on children in the city. If we directed funding more effectively toward prevention activities—toward more prenatal care for mothers at high risk for low birthweight babies, for example—we would be taking steps toward improving the health of our city's children and helping to reduce the costs associated with inpatient care by removing the necessity for many admissions.

The second way to make delivery of health services more accessible to children is through closer coordination of the child health activities of the Health and Hospitals Corporation and the Department of Health. In its 34 child health stations, the Health Department offers preventive services to children under six years of age. In the 21 pediatric treatment centers, the zero-to-six-year-old population receive preventive services as well as care for minor illnesses, and six-to-12-year olds receive care for minor illnesses but no preventive services. Together, the child health stations and pediatric treatment centers provide 325,000 visits annually.

In the child-health services in its facilities, the Health and Hospitals Corporation provides more than 900,000 visits to children annually. It is often the

provider of last resort, but currently applies a sliding fee scale to all children using their clinics. Even where there are provisions for waiver, they are often not understood and often perceived by families as a barrier to care. Removing billing for child health services would be a major step in increasing accessibility.

We are actively discussing and moving toward resolution on a number of issues with the Health and Hospitals Corporation. These include developing uniform methods for referral or flow of information between the two agencies' sites, ensuring that all Health Department physicians have admitting privileges at corporation hospitals, and engaging in a joint planning process whereby primary care that can best be delivered by corporation facilities is not duplicated by the Health Department, and vice versa.

We have already agreed upon issues of malpractice coverage for health department physicians and child abuse referrals and coordination of care; joint planning for provision of primary care services, as I mentioned, continues.

In an ideal setting, social services for families—welfare, and related services—should be located in, or attached to, primary care facilities.

Third, we must pursue additional ways to reach children in need. The large number of children living in conditions of poverty, homelessness, and overcrowding in this city leaves a great deal of unfinished business concerning their preventive and clinical care. Despite the best efforts of the voluntary sector, of the city public health services, and of the world's largest municipal hospital system, children are going without physician visits, without immunizations, without proper monitoring of nutrition and growth, and are at increased risk of communicable diseases.

Of the nearly 500 cases of confirmed measles reported in 1987, for example, 41% were among children under 16 months of age; 72% were among children under five years; cases are concentrated in zipcode areas in Mott Haven, Morrisania, and Tremont in the South Bronx, Brownsville in Brooklyn, and Corona and Jamaica East in Queens. One community district in the Bronx reported a rate of 608 cases per 100,000 children. Almost 80% of the children living in one of the city's largest welfare hotels have incomplete immunizations, as do many foreign-born children.

Clinical pediatricians must foster primary health care in areas of greatest need. We must return to our emphasis on community access and, especially, outreach, which has languished—and in some cases, succumbed—during the past 15 years. We must look at new forms of primary and emergency care,

increased ambulatory-based therapeutic approaches to mental health and drug and alcohol services, enhanced women's and children's services, and ambulatory and long-term care.

In New York City we have a number of interesting models of primary care in schools to examine, notably the primary care demonstration projects funded by the New York State Department of Health. These programs are supported by community providers (hospitals or neighborhood health centers), and provide strong links between schools and backup providers. These models facilitate children seeing providers by having care on-site, by allowing care to be given with an annual blanket consent, and by eliminating all financial barriers. Problems, however, that would affect provision of comprehensive primary care in a school-based clinic include questions of cost-effectiveness; the lack of available space in most of the city's overcrowded secondary schools; and the wide variation in community needs, necessitating school-based care specific to age groups, school districts, and perhaps even to individual schools.

While school-based primary care is an objective we should move toward, especially with regard to adolescents, it may be more feasible in the short run to explore the possible development of Health Department facilities and Health and Hospitals Corporation clinics providing primary health care to younger school age children in off-site primary health care networks. A wider technical range of services beyond those provided through school-based clinics would be available, especially during the summer and school holidays.

The final way I want to discuss for making health services accessible to children is by strengthening our outreach and advocacy activities. Outreach plays a crucial role in Phase II of the Mayor's Initiative to Reduce Infant Mortality. By the end of fiscal 1988, we shall be providing intensive services in four geographic areas of high infant mortality rates where public health nurses and advisors work with community groups to counsel and refer pregnant women who have traditionally not sought prenatal and pediatric care to local providers for medical and social services. As planned, in fiscal 1989 this service will be expanded to five additional neighborhoods.

We must apply whatever considerable leverage we can in advocacy for social action against the triple problems of access to care, the destructive elements of new lifestyles, and substance abuse. When we care for a child from the middle class, our concern embraces the child's entire life environment. With a child of poverty we are faced with that child's life environment. This means confronting failures of our formal and informal educational sys-

tems, chronic unemployability, the too frequent drift into a lifetime of crime and drugs, collapse of the nuclear family, and the housing crisis in the city. These are not only the causes of child health problems, they are reflections of them as well.

To raise but one example of the need for positive advocacy: Almost one-quarter of New York City children have no health insurance. If Medicaid eligibility had kept pace with the poverty line, many of these children would have Medicaid. Data indicate that children with Medicaid appear to have access to hospital-based sites at voluntary facilities, while uninsured children may be receiving continuing and nonemergency care only to the extent that a municipal facility is accessible. Additionally, the city would have Medicaid revenues to improve the quality of the programs offered to children, which would enhance the working of the system.

New York City's children have long been the locus of a variety of medical and public health problems. Today children continue to need a breadth of services, especially concerning the AIDS epidemic and reproductive services. There are no quick fixes to these problems. To address the problems of access to care and quality of care that have arisen out of the fragmented system of child health services, the mayor has established the Commission on the Future of Child Health in New York City. The Commission's charge is to review the current epidemiologic profile of city children, including existing child health services, and identify changes in the organization and delivery of services that must be made at local, state, and federal levels. This Commission will provide us with the mechanism we need for a five-to-ten-year coherent perspective on what steps must be taken to more effectively address the health of city children.

The next decade will be upon us rapidly. We cannot wait for social attitudes to return to a redetermination to build the just and egalitarian society that would remove the conditions of poverty in which too many of our city's children live. We cannot afford to let more time pass without taking those steps we can to finish our unfinished business, or we shall continue to fail our children into the 1990s.